

Testimony by the Honorable Ted Strickland
Governor of the State of Ohio
Before the U.S. House of Representatives Committee on Energy and Commerce,
Subcommittee on Health
February 26, 2008

Mr. Chairman, Ranking Member Deal, and my former colleagues of the Subcommittee on Health, it is my honor to be sitting on the other side of this committee room today to talk with you about the state-federal partnership that makes Medicaid and SCHIP. I want to begin by thanking many of you and the majority leadership of Congress who have worked on a bipartisan basis to reauthorize SCHIP. It is unfortunate that the President has twice vetoed these measures, but I hope that Congress will continue to press this issue until the program is reauthorized.

As Governor of the State of Ohio, I have come to know well how the administrative actions of a federal agency can scuttle the carefully developed and negotiated bipartisan agreements that state legislatures reach to provide health coverage for those who need it most. I am here today to talk about three major topics:

1. The Center on Medicare and Medicaid Services (CMS) August 17 directive is a blatant attempt to thwart the will of Congress and its apparent extension to Medicaid is without any basis in law. The result in Ohio is that 20,000 uninsured children with family incomes between 200 and 300 percent of the federal poverty level remain uninsured;
2. There is a clear need for a Congressional prohibition on CMS regulations and directives that either exceed its authority or violate legislative intent. Recently the U.S. Department of Health and Human Services (HHS) has gone so far as to propose giving the Secretary of HHS authority to overrule any decision by its Departmental Appeals Board; and

3. The urgent need for Congress to enact legislation providing enhanced Federal matching funds to states such as Ohio that are experiencing both an economic slump and increasing Medicaid caseloads and to reject the Presidents ill conceived Medicaid budget proposals.

Ohio is currently facing tough economic times and Ohio families are struggling with the increased costs of food, energy, and other everyday expenses. For many of these struggling families Medicaid or SCHIP provides a lifeline that most could not do without. That is why I believe that the President could not have picked a worse time to propose cuts in Medicaid funding and to limit state flexibility to offer assistance to families and their children as well as others who depend on these vital programs. The improper denial of Ohio's bipartisan plan to cover more children under Medicaid, the failure to increase federal Medicaid matching funds during this economic downturn, the score of proposed CMS Medicaid regulations that violate legislative intent and the Presidents proposed federal budget will result in fewer children having access to health care coverage and to health care services. This is a tragedy for Ohio's uninsured children and their families, for the State of Ohio, and for this country. I believe that Congress must take action now to overturn policies that violate congressional intent and or the law and should prohibit the administration from adopting similar policies or regulations going forward.

Ohio's Experience in Expanding Health Care for Uninsured Children

When I was elected Governor 16 months ago, I traveled across the State of Ohio and in the course of those travels I met scores of families who were without healthcare coverage. What was particularly disturbing to me was the fact that there were approximately 156,000 Ohio children without health insurance. I knew children without access to health care coverage were

more likely to go without preventive care, and to face delays in getting treatment. I also understood that a lack of health care coverage could hamper a child's ability to get a good education.

I met a small business owner from Shelby County. I would not consider him poor by any means, but certainly not wealthy. His son was diagnosed with Leukemia when he was only 18 months old. Happily, this youngster was treated and is now ten years old. But because commercial health insurers are reluctant to cover children with a medical history of Leukemia or other serious diseases, this man cannot afford to buy insurance for his son.

I met a single mother from Van Wert, Ohio. Her two children are enrolled in Ohio's SCHIP program. She told me she refused a promotion at work because the extra salary will not be enough to buy health insurance for herself and her children. And the increase in salary will put her over the income limit for SCHIP coverage.

Numerous Ohio families find themselves in these same situations. These folks have done nothing wrong. They are just working and trying to get ahead. And yet, they are victims of a system that fails to meet their needs, is lacking in compassion, and defies common sense.

To address this, I worked with the Ohio General Assembly to enact a historic, bipartisan biennial budget that was passed with only one dissenting vote. This budget funded coverage under Ohio's State Children's Health Insurance Program to Ohio children whose parents make up to 300 percent of the federal poverty line. For a family of three, for example, that's an annual

family income of about \$52,800. We projected an additional 20,000 children would receive health care coverage under this initiative. Ohio acted in good faith and we believed our proposal was consistent with the Bush administration approach to Medicaid and SCHIP, an approach often touted by former Bush HHS Secretary Tommy Thompson who provided states with great flexibility in terms of deciding who got what benefits under Medicaid.

We were trying to help children like Emily Demko a little 3-year old girl in Albany, Ohio whose story we learned about through Voices for Ohio's Children. Margaret Demko and her husband, of Albany, Ohio (near Athens) waited a long time to become parents—nine and a half years of hoping and undergoing fertility treatments. Finally, in 2004, Margaret gave birth to Emily by emergency C-section after 36 hours of labor. The couple had no idea that their baby would be born with any difficulties, but nine hours after birth, Emily was transferred from the regional hospital where she was born to Columbus Children's Hospital. Doctors suspected a congenital heart defect, respiratory problems and Down Syndrome.

After six days in the Neonatal Intensive Care Unit, the final diagnosis was Down Syndrome. And so Emily, whom her mother describes as “a happy, healthy little girl with some extra chromosomal material,” was sent home. The couple rapidly decided that Emily's special needs and a lack of appropriate child care in Athens County meant that it would be best for their family if Margaret stayed home to care for Emily. She left her job, and that ended the family's health coverage. Margaret's husband, a self-employed contractor with fluctuating income, has no access to employer-based insurance.

Being without health coverage “took awhile to sink in,” Margaret says, especially while adjusting to life with a new baby and learning everything she could about Down Syndrome. But when it did, Margaret applied for Medicaid for Emily; she received coverage beginning in the fall of 2005. Emily began speech, physical and occupational therapy at Columbus Children’s Hospital and made great progress. “Therapy helped Emily learn to walk before the age of 2,” reports Margaret, “which is unusual for a child with Down Syndrome. Her manual dexterity is almost age-appropriate and she has recovered from other issues typical for children with Down Syndrome.”

But in early 2007, Emily’s Medicaid coverage was up for redetermination, according to Margaret, and she was told by a new case worker that her husband’s income was \$300/year over the limit for Emily’s coverage to continue. And so, in March 2007, Emily became uninsured. “Emily needs insurance to cover her therapy,” says Margaret, “and for the ordinary care that all children need. Her therapy costs \$479 each week, and it helps foster the skills that will give Emily the best ability she can develop. I want my daughter to become a self-sufficient, productive member of society—she, and other people with Down Syndrome, is capable of that. Therapy helps make that happen, but we need health insurance to help pay for it.”

When I was in these esteemed halls and on this committee, we debated numerous times the need for uninsured children like Emily Demko to have access to health care coverage. It was this committee that served as a driving force behind enacting the original State Children’s Health Insurance Program (SCHIP) legislation in 1997. I am proud to have supported a policy change resulting in millions of uninsured children having access to well child visits, immunizations, doctor visits, and hospital stays. Without SCHIP, many working parents would not be able to

afford health care services for their children. So after garnering virtually unanimous and bipartisan support of the Ohio General Assembly to expand Ohio's Medicaid/SCHIP program to serve children with incomes between 200 and 300 percent, I fully expected that CMS would quickly approve Ohio's state plan amendment to accomplish this. But I was wrong, just a few months after we passed our budget the federal government would unilaterally change the rules of the game.

We submitted our state plan amendment to the CMS on September 28, 2007 and asked for approval of our plan to expand Medicaid eligibility for children with incomes between 200 and 300 percent of the federal poverty level. On December 20, we received a letter from the CMS turning down our request to expand eligibility. The stated reason for the denial was that we had not requested the enhanced SCHIP match rate for our expansion. Put another way, we had not asked the federal government for enough money. Now I have only been Governor of the State of the Ohio for a little over a year, and I have to tell you this is the first and only time we have been told by the federal government that the reason they are saying "no" is that we have not asked them for enough money.

But this clever bureaucratic maneuver was really just an attempt to apply the August 17 SCHIP guidance to Ohio even though we were applying under Medicaid and not SCHIP. Because CMS knew that if we had applied for the same expansion under SCHIP at the higher federal match rate, they would have also turned us down, and it would not be because we did not ask them for the right amount of money, it would have been because neither Ohio nor any other state can meet the August guidance. To this day, Ohio has seen nothing in federal law that would

prevent us from covering children in Medicaid at any income level using the 1902 (r) (2) income disregards as long as we are willing to provide the requisite state match. So while the bureaucrats may have congratulated themselves on their clever maneuver, nearly 20,000 children remain uninsured and 3-year old Emily Demko is still without health insurance.

Of course, the State of Ohio has not stood still as a result of this federal rejection. I have met personally with HHS Secretary Michael Leavitt to make our case and our staff within the Ohio Department of Job and Family Services have worked with CMS to recently submit a state plan amendment under SCHIP to cover children with incomes between 200 and 250 percent of the federal poverty level. We have not received word yet from CMS whether or not this plan will be approved. At the same time, we are consulting with Ohio's legislative leadership regarding how we can offer coverage to those children with incomes between 250 and 300 percent of the federal poverty level. Emily Demko fits in this category.

Ohio has filed an administrative appeal of the CMS denial of our original proposal to extend Medicaid coverage to children between 200 and 300 percent of the federal poverty level. At the same time, we have not ruled out further legal action pending the outcome of the administrative appeal.

A much better alternative would be for Congress to legislate a prohibition on enforcement of the August 17 guidance until larger SCHIP reauthorization issues are settled. Congress has already wisely approved moratoriums on other proposed CMS regulations, but any effort to extend those moratoriums should be expanded to include a moratorium on the August 17 guidance. Congress thought they were maintaining the status quo on SCHIP when they passed the extension last year, but CMS' denial of Ohio's expansion shows it is not interested in

maintaining the status quo and as a result, we are in danger of seeing the unraveling of state Medicaid and SCHIP coverage for children. In addition, the President's Medicaid budget proposals show the administration wants to further expand the number of children covered by the guidance to those with incomes between 200 and 250 percent of the federal poverty level. Such an approach could prevent Ohio and other states from offering access to coverage to thousands of uninsured children.

Proposed CMS Regulations Will Weaken Ohio's Health Care System

In 2007 the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services issued a number of Medicaid regulations that have enormous consequences for states and millions of Americans served by the Medicaid program. Many of these regulations alter long-standing Medicaid policy, but they have been proposed without any corresponding legislative action. CMS estimated just six of these regulations could result in an estimated \$12 billion reduction in federal Medicaid spending over the next five years. In our view these are really budget cuts disguised as regulations.

We applaud Congress for wisely implementing a moratorium on several of these regulations that CMS has attempted to implement. We believe Congress must now act quickly to *expressly* prohibit implementation of these burdensome and ill thought out regulations. Without such action, costs will simply be shifted to states and local governments that are already being hard pressed by a weakened economy. It is not just state Medicaid programs that will be affected by these cuts. The impact will be felt by our schools, child welfare agencies, colleges and universities, and many others.

For example, one of these regulations deals with the issue of targeted case management.

The Deficit Reduction Act (DRA) of 2005 contained a section to clarify the Medicaid definition of case management when covered as a Medicaid state plan service. This clarification intended to curb improper billing of non-Medicaid services to the Medicaid program. CMS issued an Interim Final Rule (IFR), effective on March 3, 2008, to implement this section of the DRA.

Ohio is concerned CMS is using this IFR as a vehicle to eliminate administrative case management as an option for the 1915(c) Home and Community-Based Services (HCBS) waiver programs through which states provide less-expensive community care as an alternative to more expensive institutional care. Waiver case managers are key to assuring waiver consumer health and safety, and cost-effective community service delivery. The elimination of administrative case management goes well beyond the Congressional intent of the DRA and will have a devastating impact on several of Ohio's 1915c HCBS waivers.

Though the proposed rules do not specifically address HCBS waivers, CMS has gone on record stating their intention that states will no longer be permitted to choose to provide case management as an administrative activity under an HCBS waiver. Historically, administrative case management combined what the IFR now defines as case management, such as designing and coordinating service plans, with certain Medicaid administrative activities, sometimes referred to as gate keeping activities. Gate keeping includes such activities as pre-admission review, prior authorization and eligibility determination. Ohio questions CMS' authority to extend the provisions for state plan services as contained in the Deficit Reduction Act to other

forms of case management, including case management services provided through a 1915(c) waiver or under an administrative reimbursement mechanism.

CMS is differentiating case management from administrative activities, and indicating any willing, qualified provider may furnish case management, whereas only the state Medicaid agency can perform administrative activities. The provision prohibiting case managers from serving as gatekeepers will limit their ability to effectively coordinate services and manage program costs, especially as part of an HCBS waiver program. Limiting administrative functions such as level of care determinations, service plan approval and prior authorization of waiver services to only Medicaid state agency staff will have a major impact on access, efficiency and cost.

An advantage of administrative case management is the state's ability to limit providers to entities having expertise in serving an HCBS waiver's target population. For instance, in Ohio's PASSPORT HCBS Waiver that serves more than 27,000 elderly consumers, a network of 13 PASSPORT Administrative Agencies (PAAs), located in the state's 12 Area Agencies on Aging as well as one not for profit agency, operate the program regionally and provide administrative case management to PASSPORT waiver consumers. Ohio has used administrative case management in the PASSPORT waiver for 24 years with approval from CMS. The PAAs currently employ approximately 550 licensed social workers and registered nurses to perform the case management function. If CMS eliminates the option of administrative case management, the PAAs will be forced to lay off their current case managers.

The IFR requires a consumer have only one Medicaid case manager, and most individuals in Ohio's Medicaid HCBS system have only one. However, Ohio's system also supports the use of an inter-disciplinary approach, when consumer needs cross delivery systems. Requiring a consumer to have only one Medicaid-funded case manager may result in an individual receiving case management services from a case manager inexperienced in serving certain populations or needs. Case managers will need to expand their expertise and devote extra time to manage across all service delivery systems and providers. This will result in the need for smaller case loads to accommodate an increase in case management intensity, which will lead to increased program operation, costs.

The IFR allows individuals to decline case management services in contradiction to CMS' HCBS waiver program requirements. HCBS waiver provisions require each participant receive services furnished under a comprehensive plan of care clearly delineating the consumers' needs. Creating such a plan is a case management function under a HCBS waiver. If the case manager has no role in developing, coordinating and monitoring a comprehensive plan of care, Ohio can neither responsibly manage waiver program costs nor assure participating consumers' health and safety.

Historically, to avert the possibility of conflict of interest, Ohio has prohibited direct care service providers from also providing case management. The IFR allows direct service providers to also furnish case management, inviting the possibility of self-dealing.

Ohio also is concerned about the new 60-day limitation introduced in the IFR on coverage of community transition coordination, a state plan case management service component, consisting of all the tasks involved in helping an institutionalized individual relocate to the community. Currently, Ohio's MR/DD targeted case management service, provided as a state plan service and not as an HCBS waiver service, covers community transition during the last one hundred eighty days (180) of an individual's stay in an institution. This amount of coverage is consistent with CMS policies issued in response to the Olmstead court decision. In some cases, 180 days is not enough time to put into place all the necessary community supports to effectively transition an individual from an institution to a community setting. Moreover, the IFR requirement that FFP is not available until the consumer leaves the institution and is receiving medically necessary services coordinated by a community case management provider, coupled with the IFR requirement that a consumer can decline case management services, creates a disincentive for community-based case management providers to deinstitutionalize individuals.

CMS projects the IFR will produce Medicaid cost savings. With potentially many new agencies and individuals providing case management and with the loss of key oversight for Medicaid waiver spending, it is simply not possible to achieve the savings CMS assumes in its impact statement. This is even more evident by the fact that if administrative case management is eliminated in favor of targeted case management, states like Ohio will be able to bill case management at the higher FMAP rate. Ohio projects an increase in CMS expenditures of \$5 Million from this change alone. Ohio believes the changes will result in an additional increase in costs due to increased staffing needs, decreased controls, and significant changes to information technology systems to accommodate a fifteen minute billing unit, newly introduced in the IFR.

For example, for Ohio's waiver for the elderly, such changes may result in increased costs of over \$6.1 million (all funds) to accommodate the regulatory provisions.

CMS indicates the only entity impacted by the proposed regulations is the state. In Ohio, these regulations, especially if applied to 1915(c) waivers, impact local entities currently responsible for case management activities whether the activity is currently conducted as an administrative function or as a service.

As I mentioned at the beginning of my testimony, we are also concerned about proposed HHS/CMS regulations published in the Federal Register on December 28, 2007 entitled *Revisions to the Procedures for the Departmental Appeals Board and Other Departmental Hearings* which would significantly weaken the Departmental Appeals Board (DAB) and cause a wholesale revision of the current method of resolving disputes between states and the federal government. Congress commissioned the DAB to give states a method of seeking review of Secretarial decisions and made a conscious decision not to give the Secretary the authority to review any decision by the DAB. The regulations seek to undo current practice and propose to give the Secretary the power to overturn decisions by the DAB. In this instance the Secretary is asking to be both the judge and the jury. The proposed regulations go even further by forbidding the DAB from invalidating any federal decision if such a decision runs contrary to published or even unpublished guidance. This means that states could be held accountable to follow rules or guidance that was never properly released or were released without any proper notice. This is yet another example of HHS and CMS seeking to act in a way that is contrary to the law, and to well established notions of due process and fair play.

Another area of concern is the administration's regulations that would wipe out Medicaid reimbursements for Graduate Medical Education (GME). The regulations declare that state Medicaid programs "must not include payments for graduate medical education to any provider or institution or include costs of graduate medical education as an allowable cost under any cost-based payment system." The Association of American Medical Colleges (AAMC) has filed comments that the rules "represent a major and abrupt reversal of long standing Medicaid policy." They also contend the rules could have a negative impact on the health care system. According to the AAMC, teaching hospitals represent 20 percent of all hospitals, and 42 percent of all Medicaid discharges. Ohio's teaching hospitals will lose millions of dollars if these regulations and or proposals are allowed to proceed and it will undercut their ability to train the next generation of physicians who will be called upon to treat our Medicaid consumers.

Other regulations of concern include those on rehabilitation services, school-based services, hospital cost limits, and provider taxes. Each of them has the potential to undermine the state's health care system and limit access to health care.

Federal Fiscal Relief Needed to Avert Medicaid Cuts

It is clear to me that Ohio's economy is struggling, with both unemployment and Medicaid caseloads increasing. As of December 2007, our Medicaid caseloads were 22,821 over our budgeted projections and there is every reason to believe that our Medicaid caseloads will continue to exceed budgeted levels. When we started to see these caseload numbers rise we delayed planned increases in the Medicaid rates for community providers and hospitals, and also

delayed restoration of adult dental benefits, which was eliminated by my predecessor. Since that time, we have decided to proceed with the planned rate increase for community providers and to restore adult dental benefits, but we were unable to afford a planned rate increase for hospitals. Even though Ohio faces a biennial budget shortfall of \$733.4 million we are committed to living within our means and investing in what matters to Ohio, and what matters in this instance is access to health care coverage for children and other vulnerable populations.

Bush Medicaid Budget Puts Children, Families, and Persons with Disabilities At Risk

According to the American Public Human Service Association, the budget submitted by President George Bush seeks to cut Medicaid spending by \$17.3 billion over the next five years, and over half of these cuts are the result of simply reducing the federal financial participation in Medicaid expenditures. The administration is proposing to reduce federal financial participation for the following activities:

- Compensation or training of skilled professional medical personnel (and their direct support staff) of the state Medicaid or other public agency;
- Preadmission screening and resident review for individuals with mental illness or mental retardation who are admitted to a nursing facility;
- Survey and certification of nursing facilities;
- Operation of an approved Medicaid Management Information System (MMIS) for claims and information processing;
- Performance of medical and utilization review activities or external independent review of managed care activities;
- Operation of a state Medicaid fraud control unit (MFCU);
- Family planning services;
- Targeted case management; and
- Medicare Part B Premium Costs (Q1 Program Match Rate).

There is no justification for these proposals, and many of them defy common sense. The federal government should be encouraging states to do more in areas like fraud prevention,

preadmission screening for nursing facilities, automation, and health information technology, not less.

Another area of concern in the President's Medicaid budget is the proposal to extend the August 17 guidance to children whose families have incomes between 200 and 250 percent of the federal poverty level. States would be required to enroll 95 percent of their eligible Medicaid and SCHIP child populations with annual family income less than 200 percent of the federal poverty level. States failing to comply, and we do not know of any state that could comply with this standard, are subject to a 1% reduction in their federal financial participation rate.

We are also opposed to another apparent proposal placing new limits on how states calculate a family's income for purposes of qualifying for Medicaid or SCHIP. Most states, including Ohio, determine family income by deducting a certain portion of income (through earned income disregards) to account for work related expenses and child care. If these new budget provisions/rules are allowed to go into effect, it is virtually certain many Ohio children who are eligible today would no longer be eligible for our state children's health insurance program and would find themselves uninsured.

Finally, it is not clear to us the President's budget contains sufficient funding to either expand the program to serve additional eligible children in Ohio or to even serve all the Ohio children who currently depend upon the program.

In closing, I want to end my testimony where I started, by calling on Congress to assert its rightful authority over the Medicaid and SCHIP programs and to prohibit CMS from enforcing the August 17 directive; to prohibit CMS from promulgating regulations, directives or guidance

that either exceed their authority or violate legislative intent; and to immediately pass legislation providing enhanced Federal matching funds to states such as Ohio that are experiencing both an economic slump and increasing Medicaid caseloads and finally to reject the Presidents Medicaid budget proposals which, if passed, would have the effect of reducing access to health care for thousands of Ohioans.

Thank you again for the opportunity to testify I would welcome any questions that you may have.